# PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, October 19, 2004, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Ms. Christine Ferguson (Chair), Ms. Maureen Pompeo, Mr. Albert Sherman, Ms. Janet Slemenda, Mr. Gaylord Thayer Jr., and Dr. Martin Williams. Ms. Phyllis Cudmore, Mr. Matt George, Jr., and Dr. Thomas Sterne absent. Also in attendance was Attorney Donna Levin, General Counsel.

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Chair Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

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The following members of the staff appeared before Council to discuss and advise on matters pertaining to their particular interests: Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, Ms. Joyce James, Director, Determination of Need Program; Sharon-Lise Normand, PhD, Professor, Department of Health Care Policy, Harvard Medical School; David Shahian, M.D., Chairman, Department of Thoracic and Cardiovascular Surgery, Lahey Clinic; and David Torchiana, M.D., Chairman and Chief Executive Officer, Massachusetts General Physicians Organization.

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## RECORDS OF THE PUBLIC HEALTH COUNCIL:

Records of the Public Health Council Meeting of August 24, 2004 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve Records of the Public Health Council Meeting of August 24, 2004.

**PERSONNEL ACTIONS:**

In a letter dated October 8, 2004, Val W. Slayton, MD, MPP, Interim Director of Medical Services, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the various medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Interim Director of Medical Services for Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning October 1, 2004 to October 1, 2006:

| **PHYSICIAN APPOINTMENTS:** | **STATUS/SPECIALTY:** | **MEDICAL LICENSE NO.:** |
|---|---|---|
| Lawrence Climo, MD | Provisional Active Psychiatry | 32513 |
| Joseph Jackson, DO | Provisional Affiliate Psychiatry | 217374 |
| Peter Newberry, MD | Provisional Affiliate Psychiatry | 220693 |

| **PHYSICIAN REAPPOINTMENTS**: | **STATUS/SPECIALTY:** | **MEDICAL LICENSE NO.:** |
|---|---|---|
| Teresita Buenaventura, MD | Active Internal Medicine | 51207 |
| Herman Haimovici, MD | Consultant Radiology | 29566 |
| Beatrice Szeto, MD | Active Psychiatry | 210162 |
| David Berman, MD | Consultant Urology | 51207 |

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In a letter dated October 18, 2004, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of an appointment and reappointments to the medical staff and allied health staff of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital be approved as follows:

| **PHYSICIAN APPOINTMENT**: | **STATUS/SPECIALTY:** | **MEDICAL LICENSE NO.:** |
|---|---|---|
| James Feldman, MD | Active Psychiatry | 59346 |

| **PHYSICIAN REAPPOINTMENTS**: | **STATUS/SPECIALTY:** | **MEDICAL LICENSE NO.:** |
|---|---|---|
| Salah Alrakawi, MD | Active Internal Medicine | 144525 |
| David Pimentel, MD | Consultant Internal Medicine; Cardiology | 150203 |
| Rochelle Scheib, MD | Active Internal Medicine; Oncology/Hematology | 58167 |
| Tolga Ceranoglu, MD | Consultant/Psychiatry | 215949 |
| Peter Barrett, MD | Consultant/Radiology | 31530 |
| Albert Franchi, MD | Consultant/Orthopedic Surgery | 49738 |
| Julie Kim, MD | Active/Surgery | 214157 |
| Olarewaju Oladipo, MD | Active/Orthopedic Surgery | 151848 |

**ALLIED HEALTH PROFESSIONALS:**

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|---|---|---|
| Katherine Keefe, PA | Allied Health Professional | 228 |
| Gail Polli, CNS | Allied Health Professional | 146723 |

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**PRESENTATION: NO VOTE/INFORMATION ONLY**

**"CARDIAC SURGERY OUTCOMES IN MASSACHUSETTS", BY PAUL DREYER, PHD, ASSOCIATE COMMISSIONER, CENTER FOR QUALITY ASSURANCE AND CONTROL, DEPARTMENT OF PUBLIC HEALTH; SHARON-LISE NORMAND, PHD, PROFESSOR, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL; DAVID TORCHIANA, M.D., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION:**

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, said, in part, "…In 1998, there was an act that created a Cardiac Surgery Task Force, which was mandated to make recommendations by January 1, 1999. So what we have done is implemented

the Commission's report. We promulgated regulations in early 2001 that mandated reporting of a consistent data set from all hospitals that were performing cardiac surgery…"

Dr. Sharon-Lise Normand, Professor, Department of Health Care Policy, Harvard Medical School, said in part, "…I am going to report today on cardiac surgeries performed between January 1, 2002 and December 31, 2002 in the Commonwealth of Massachusetts. The public report serves many purposes, some of which will be to inform patients, consumers, and physicians in choices about hospitals. What I am going to talk about today specifically is to provide a measure, and that is a projection of mortality at each hospital today in the Commonwealth if quality remained the same as in 2002, because we are using 2002 data. And the final purpose is to increase hospital quality through sharing of information…We are looking at Coronary Artery Bypass Graft Surgery, which I am going to call CABG. There were four thousand six hundred, approximately, admissions in which isolated CABG was performed in thirteen institutions in the Commonwealth in 2002. Two cardiac surgery programs were new…There are two important key facts. One is that there are no statistically significant differences among hospitals in thirty-day mortality rates; and, moreover, the two new programs performed as well as their peers during this time frame. Those are the results."

Dr. Normand continued, "…In 2002, in the Commonwealth of Massachusetts, CABG surgery counted for about sixty percent of the 7,661 cardiac surgeries performed in the Commonwealth in calendar year 2002. Data collection is very important and we wanted to make sure that we had very good data in order to measure the quality of care by thirty-day mortality…There are lots of things that go into figuring out what thirty-day mortality rates are for particular institutions. We estimate a model. We use the case mix. We use the number of cases at that hospital. We don't know that number with certainty. And so, hence, the interval estimate is very important. So, the Standardized Mortality Incident Rate should only be interpreted in the context of its interval estimate…If the interval is completely above the state rate which is 2.19 percent in 2002, then the hospital is worse than expected. If that interval estimate is completely below the 2.19 percent, then the hospital did better than expected. In 2002, there were a hundred and one deaths within thirty days of surgery. That represents a rate of 2.19 percent…The adjusted rate, the raw rate in Massachusetts is 1.19 percent, which is very low. Again, thirty-day mortality rates are very low in the Commonwealth, and I cannot emphasize that enough. Again, no statistical differences among hospitals in terms of thirty-day mortality rate…"

Dr. David Shahian, Chairman, Department of Thoracic and Cardiovascular Surgery, Lahey Clinic, said, "Cardiac surgery report cards have been highly contentious in many other states where they have been mandated. In contrast, implementation of the Massachusetts report card has been remarkably smooth and free of controversy. I think credit for this must be given to all the participants in the process…As to the results themselves, they are certainly good news for the citizens of the Commonwealth. Overall, unadjusted mortality for coronary bypass surgery in Massachusetts is among the very lowest…There were no statistically significant differences

among the programs. Patients may use traditional criteria for selecting their cardiac surgery provider, such as the recommendation of their primary physician or their cardiologist, or the geographic proximity of the program to their home, knowing that wherever they go, they will be in safe hands. Although these are excellent results, nobody involved in the project is content to rest on this initial good news. Cardiac surgeons have already begun planning how best to utilize the data which has been generated in order to better understand how we deliver cardiac surgical care, and to find ways to continually improve these processes of care."

Dr. David Torchiana, Chairman and Chief Executive Officer, Massachusetts General Physicians Organization, said in part, "…We have high quality cardiac surgery programs in Massachusetts, and patients in the Commonwealth who need bypass surgery may feel comfortable that all of our institutions, including new ones, are up to the task of providing high quality care…Before long, heart surgeons and cardiologists of the state will have a database that is a rich source of information to analyze and to identify best practices, and to try to figure out the most effective solutions to the problem that we all confront in delivering complex care to increasingly complex patients. We know that over time, from experience in other regions, that outcomes will vary among institutions, but our hope is that, by working together, we will be able to continuously improve the outcomes for the state as a whole. I want to talk about risk adjustment. Although much of the commentary directed at health care quality these days is negative, the fact is that the mortality rate for patients with atherosclerotic heart disease has fallen by nearly two-thirds in the last fifty years. Bypass is part of the reason why. I would say it is a big part, and it would be nice to have as our goal a zero percent mortality rate for coronary bypass surgery; but, in fact, that would be the wrong goal. Even if every surgeon did every operation perfectly and made every management decision without the slightest mistake, we should still expect that some patients will die after coronary bypass surgery. There are a number of reasons for this, but here is the most important one. Sometimes the procedure needs to be done in risky circumstances, when the chance of death is high, but would be higher or even certain without surgery. We know that when this surgery has the highest risk, it may also have the highest potential benefit. Just looking at survival after bypass surgery can miss the big picture. It may lead to wrong decisions, or even denial of care for high risk patients. The real measure of survival is survival for all patients with coronary disease, and that number may actually be better with a higher overall surgical mortality because it means that deserving patients are not being denied a chance for benefit. The is what risk adjustment is for in the state report, and that is why we report risk adjusted results, instead of just giving the raw data. The idea is to prevent hospitals and doctors from being mislabeled for doing what is the right thing, that is, taking on the challenging and difficult cases. As surgeons, we want all of our patients to do as well as possible. We want to continuously improve our results, and we are absolutely willing to be accountable for them. It is very important that the public, and especially the members of the media, who educate the public, make the effort to understand the concept of risk adjustment and statistical significance, and use this report and these numbers with care."

Dr. Paul Dreyer, Associate Commissioner, Center for Quality, Assurance and Control, said, "Let me make a couple of comments…There are really two primary reasons that people have wanted to look at these kinds of data. The first is to enable consumers to make decisions about which hospitals to go to. We have seen that there are no differences among the hospitals. So that means for us that consumers can make their choices based on factors other than the outcomes, which is a good thing. The other major purpose for collecting these data are for the surgical community to work on quality improvement. These data and the risk adjusters that are behind them can be used in the context of quality improvement to make things better. If you participate in the discussions among the surgeons, you will hear lots of talk about why various risk factors are what they are, how to understand the interrelationships among all the factors and that kind of discussion will lead to improvement…These data will be available to the Society of Thoracic Surgeons for them to use in the quality improvement context.
The Legislature asked us to make a decision as to whether there would be material benefit for yet more surgical programs in Massachusetts. To make that determination, we need more data from the new programs…So, we will need several more years of data before we can make an ultimate determination as to what the need for additional programs is. The one point I should make is, and I don't think this was apparent in the data, the number of cardiac surgical procedures is going down. The number of CABG procedures is declining over time, both nationally and in Massachusetts, as angioplasty becomes more sophisticated. So, I think that fact will bear on our ultimate decision about the need for more programs."

Chair Christine Ferguson said, "The outcomes just confirm that we live in a state that is really the mecca for some of the best health care in the world. And so, it is great news from that perspective. It is also important for us at the Department of Public Health to continue to host and convene these conversations because the data that comes out of these studies and the Betsy Lehman Center is another area that we will be doing quite a bit of this kind of work, is really critical in terms of making fundamental policy decisions about how to pay for things, when to pay for things, what to pay for things and what kinds of outcomes to expect, what is reasonable for us to expect…In terms of looking at health care policy, what we are trying to do is look at trends. That is what is important, what the line looks like, as opposed to what it is at any given point in time, and that is critical. And then, finally, the data provides a way of internally, within the profession, continually pushing improvements and advances, and without that data, and without some way of looking across all of your colleagues, it is impossible to really know where you fit. And knowing that really does play an important role in quality improvement. So we have been very fortunate to be able to do this work in Massachusetts. There are a lot of other states that are not in a position to be able to do this, and we have got wonderful partners, and I just want to thank you all for your work, and urge you to continue pushing us and pushing the community to do this work."

**No Vote/Informational Only**

**DETERMINATION OF NEED - INFORMATIONAL BULLETIN:**

**INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS:**

Ms. Joyce James, Director, Determination of Need Program, said in part, "We request the Public Health Council's adoption of the Informational Bulletin on Annual Adjustments to the Determination of Need Expenditure Minimums. These adjustments are being requested in compliance with M.G.L. c.111, S25B1/2. Since the U.S. Department of Health and Human Services does not have an appropriate index, the inflation indices used by the DoN Program staff to adjust DoN threshold dollar amounts are:

Marshall & Swift……capital costs
Global Insight…… operating costs
Health-Care Cost Review

These indices have been chosen by the Determination of Need Program as an authoritative resource due to their extensive use within the health care industry to determine inflation rates for a number of health care expenditures. While each of the indices has various regional and market sector subtleties and shadings, it is important for ease of administration to use a single inflation factor for capital costs and a single factor for operating costs…Thus, Marshall and Swift's statewide figures are used for the capital cost inflation and the average of Global Insight hospital and nursing home figures is used as the basis for recalculating inflated operating costs…effective October 1, 2004."

After consideration, upon motion made and duly seconded, it was voted unanimously (Chair Ferguson, Ms. Pompeo, Ms.Slemenda, Mr. Thayer, Jr., and Dr. Williams in favor; Council Member Sherman not present to vote; and Council Members: Ms. Cudmore, Mr. George, Jr., and Dr. Sterne absent) **to approve the Informational Bulletin on Annual Adjustments to Determination of Need Expenditure Minimums as follows:**

## EXHIBIT A

## ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS

Determination of Need Regulations 105 CMR 100.020 require the Department of Public Health to adjust expenditure minimums (for inflation).

**Capital Cost Indices (Marshall & Swift):**

| | October 2003 | October 2004 |
|---|---|---|
| **Region –Eastern** | **1989.7** | **2222.3** |
| **Massachusetts** | **1.10** | **1.11** |

$$\frac{2222.3}{1989.7} \times \frac{1.11}{1.10} = 1.1271$$

**Operating Costs (Global Insight):**

| | 4th Quarter 2003 | 4th Quarter 2004 |
|---|---|---|
| **Skilled Nursing Facility** | **1.245** | **1.291** |
| **Hospital** | **1.253** | **1.296** |

$$\left(\frac{1.291}{1.245} + \frac{1.296}{1.253}\right) / 2 = 1.0356$$

## EXHIBIT B

## ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS

### Capital Expenditures

| Project Type | October 1, 2003 | Filing Year Beginning October 1, 2004 |
|---|---|---|
| Equipment for non-acute care facilities and clinics | $568,066 | $640,242 |
| Total capital expenditure including equipment for non-acute care facilities and clinics | $1,136,133 | $1,280,485 |
| Capital expenditure, excluding major moveable equipment, for acute care facilities and comprehensive cancer centers | $10,651,247 | $12,004,549 |

### Operating Costs

| Project Type | October 1, 2003 | Filing Year Beginning October 1, 2004 |
|---|---|---|
| Nursing, Rest Homes and Clinics | $602,234 | $623,693 |

The meeting adjourned at 11:00 a.m.

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Christine C. Ferguson, Chair
Public Health Council

LMH/SB